The Hampden Hippocrat

MEMBER MEDICAL SOCIETY MAGAZINE GROUP

A Bulletin for the Hampden District of the Massachusetts Medical Society

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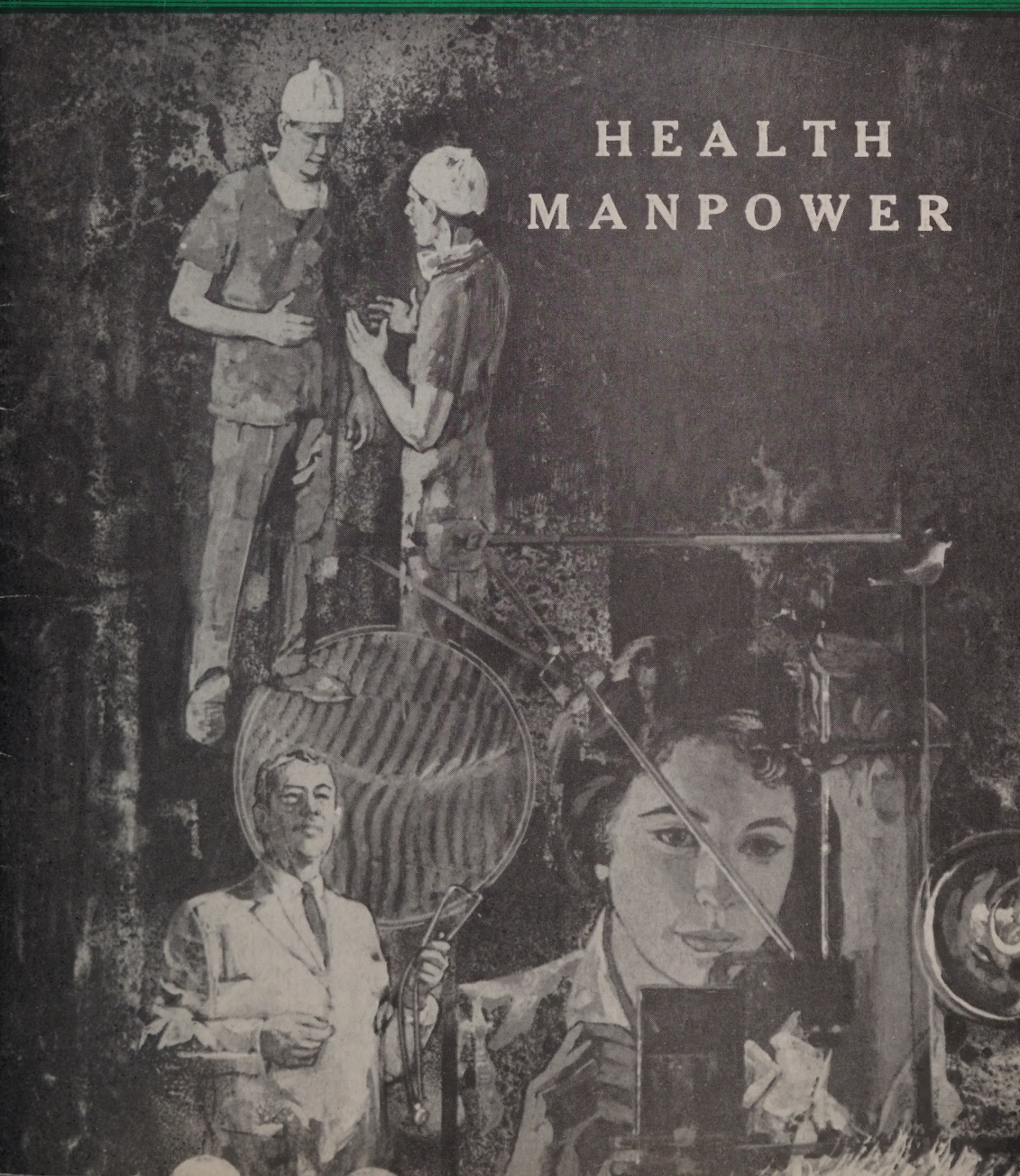

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The Hampden Hippocrat

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Hippocrates

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EDITORIAL

A MANIFEST CHALLENGE

Health services in the United States are ever increasingly becoming "big business." According to the U.S. Dept. of Labor, the total number of persons engaged in all types of health related activities is approximately 3.5 million. Excluding physicians and dentists, who are self-employed in private practice, and other professionals who may be classified in retail trade, government employees, etc.; payroll employment in such health service establishments as hospitals, nursing homes, doctors' offices, and commercial laboratories has risen from 1.7 million in 1950 to more than 2.6 million currently with a gain of another million expected by 1975. Thus, the growth rate of over 1/3 as predicted for the next decade is one of the highest of all industry groups. In fact, the health service industry is anticipated to become either the largest or second largest employer in the country.

Reasons for Growth

There are many and varied reasons to account for this rapid growth. Our affluent society is becoming intensively health conscious and is demand-

ing more and better health care. Instead of paying out of pocket or from savings or from borrowed funds with charity as the only other alternative, the American people have turned ever increasingly to health insurance plans so that about 3/4 of the population have some form of coverage. The "population explosion" with its proportionately large number of elderly has also had its effect. Increased hospital construction with and without governmental subsidy has raised manpower requirements. Likewise, technologcial advances of the past two decades coupled with promises of more to come have and will continue to add to the demand. Undoubtedly, more can be expected to result from the recently enacted social security amendments, namely, Title XVIII (Medicare), Title XIX (Medicaid), Title II (Kidicare), and Title V as well as from the various programs of the Economic Opportunity Act. Looking further into the future, a major expansion in the number, capacity, and types of services of nursing homes and home health service agencies will sharply increase requirements. The acceleration in the development of community mental center programs to return the mentally ill to the mainstream of medical care will also have its effects. Let us not forget our commitments of health services and manpower not only to the troops in South Vietnam but also the native populace. Moreover, President Johnson recently called for a marked increase in our commitment to programs of international health and education.

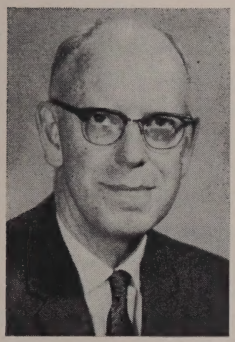
Shortages

Most authorities agree that shortages of health workers already exist in many areas and that even bigger shortages are likely to occur in the future. But how big is the current shortage? The exact magnitude cannot be pinpointed since it depends on basic assumptions and definitions. Some analysts may define the shortage as the number of actual job vacancies that are currently unfilled. Other analysts may set up some theoretical standard of adequate medical care and measure shortages against this hypothetical standard. In addition, estimates of shortages for individual occupations vary because there are differences of opinion about the proportion that each occupation should represent in the total occupational amalgam. To complicate matters more, workers in some occupations, such as in the nursing field, are interchangeable for borderline duties. There are undoubtedly many other factors involved in arriving at a precise definition of current shortages.

Estimates of shortages in future years are even more difficult to make. Crystal ball gazing in this area depends on future technological changes as well as the output of health workers from various educational and training programs. Roughly, over the next 10 years, some 100,000 new workers must be added each year to meet rising manpower requirements. An additional number must be available to replace those who are separated by death, retirement, or other reasons.

Hurley

President's Page



HEALTH MANPOWER

Health manpower is one of our most serious problems today and is one which the medical profession should strive to help solve. Federal grants of large sums of money for bright new hospitals, sophisticated equipment, and plush nursing homes are to no avail with no personnel to run them. This includes not only physicians but the whole gamut of ancillary help — nurses, laboratory and radiology technicians and even less specialized help.

Serious efforts must be made to recruit medical students, nurses, and technicians at all levels. Currently, the A.M.A. has appointed a Manpower Commission, there is a National Advisory Commission on Health Manpower, and a variety of other organizations are concerning themselves with the problem. The Mass. Chapter of the American College of Surgeons is working with the present problem of diploma schools of nursing in Mass.

There is no single or simple solution, but one avenue is open to all of us. We should do all we can as individual physicians to encourage young people of promise to enter these areas of endeavor. We are in the position of being able to explain the rewards of service in terms of personal satisfaction and, perhaps, even able to help toward improving wage scales which in some areas are not compatible with the professional accomplishment of the employee.

DONALD R. HAYES, M.D.

CLOSING IN ON THE CHALLENGE

What can be done to reduce the current shortage of health manpower as well as that looming in the future? Perhaps, there is some relief in the offing by virtue of new developments in the field of medical technology. However, this is hardly foreseeable in the near future and so we must turn to consideration of such factors as manpower analysis, distribution, utilization, and development. Such action must involve all levels of government and organizations interested and working in field of health services.

Better Utilization

One approach to the problem is to improve the utilization of workers who are currently providing health services. Hospitals and other employers should be encouraged and assisted to analyze the content of health service jobs to insure that the time of skilled workers is not wasted on routine duties and that their skills are thoroughly taken advantage of. Wherever necessary, traditional duties of today's professionals should be broken down so that "subprofessionals" or lower skilled workers, who are not in short supply, can take over the less complicated chores, thereby freeing the fully trained for prime technical tasks. Unfortunately, there seems to be some resistance to this approach on the part of some professionals who fear their calling may be reduced to a status of mediocrity or be replaced.

At the present time, incentives associated with progression from a less skilled occupation to one of higher calibre are faced with difficult barriers. Amongst the latter are such factors as educational and licensing requirements and traditional concepts pertaining to training and career mobility. Consideration should be given to the development of promotion opportunities or "career ladders" running from the least skilled through to supervisory levels.

Research should be expanded to increase the productivity of health manpower. Compared to the sophisticated knowledge of productivity in manufacturing, the health service industry is still in its infancy.

Remuneration and Working Conditions

One way of attracting and keeping more health service personnel is to improve wages and working conditions. In spite of the importance of health services, remunerations have not been comparable with those of most other personnel in other fields of endeavor. Relatively low recompense combined with difficult working conditions and inconvenient working hours account for a high rate of turnover in this field. For instance, it is estimated that the annual turnover rate is 60% for nurses, 70% for nurse aides, and more than 33% for L.P.N.'s.

Recruitment

To recruit personnel in greater numbers, the qualifications demanded of applicants should be reviewed with an eye to eliminating artificial, unduly rigid, and outmoded specifications including some official licensing requirements.

Secondly, unlimited ingenuity and effort should be expended in bringing back into the working fold the large number of professionals, technical, and skilled people who have left the health service field for one reason or another. Many women - registered and practical nurses, technicians, and therapists of various types - who have

(More on Page 6)

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left the health field to raise families or for other reasons can be induced to return if arrangements for flexible schedules for part-time work, refresher training, "baby-sitting", and the like can be made.

Education and Training

So that we can have a good supply of well trained manpower, top priority should be given to expanding our resources and practices for training health workers. Curricula should be reviewed constantly to insure that content is keeping pace with the rapidly changing technology and that the training period is kept to a minimum. Training must also be expanded to update and upgrade the skills of those currently working and to help them to advance. There is also need for expanding training for the newly emerging occupations in the health field.

The Federal Government has recognized the need for training health manpower. Assistance for training physicians and nurses under the Public Health Service Act and the Nurse Training Act and the training of health workers, primarily practical nurses and aides, under the Vocational Education Act are good beginnings. Many thousands of unemployed or underemployed have also been authorized to receive health occupation training under the Federal Manpower Development and Training Act. Disadvantaged people are being trained as home health aides and other health workers under the Community Action Program of the Economic Opportunity Act. However, a note of caution must be issued in regard to these latter mentioned programs. Specifically, qualitative standards of training programs must not become a secondary objective simply because money, which is an essential lubricant for progress, is being primarily made available to relieve unemployment.

The aforesaid undoubtedly are just a few general and broad approaches to meeting a most serious and complex problem. As time goes on, other ideas will certainly come to the fore as Dr. David E. Price has very aptly put it:

"Imagination, creativity, and minds that can cut through the cobwebs of long established procedure and find the new method that does the job faster and cheaper, these are the keys to public health progress just as they have been the keys to industrial progress."

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MEETING
OF
HAMPDEN DISTRICT MEDICAL SOCIETY
AND
HAMPDEN COUNTY BAR ASSOCIATION

DATE: TUESDAY, MARCH 7, 1967

TIME: 6:30 P.M. — Social Hour
7:30 P.M. — Dinner

PLACE: SHAKER FARMS COUNTRY CLUB
WESTFIELD, MASSACHUSETTS

GUEST SPEAKER: EDWIN J. HOLMAN, ESQ., LAW DEPT.
AMERICAN MEDICAL ASSOCIATION

TOPIC: "IMPROVING
INTERPROFESSIONAL RELATIONS"

All reservations and checks must be in before March 3, 1967. Make checks payable to Hampden District Medical Society and mail attention, Mrs. Vivian M. Purdy, Executive Secretary, Hampden District Medical Society, 1414 State Street, Springfield, Massachusetts 01109.

JOHN F. GRIFFIN, M. D., Secretary

FLORENCE NIGHTINGALE
— TWENTIETH CENTURY —

As in all disciplines, the nursing profession has undergone many changes in the past century; more changes are yet to come in our lifetime. The nursing shortage will persist and become more acute, but the more foreboding concern which faces educators, physicians and patients alike is the plan for nursing education in our decade and for the future.

Nursing education in the United States is directed by two major groups: The American Nurses' Association and the National League for Nursing. The former group in October of 1964 adopted ten guide lines for nursing education. The salient proposal called for the transfer of nursing education from the hospital to the college campus. It may be of interest to reflect that thirty years ago 98% of the nurses, who dedicated their professional life to attend the sick at the bedside, were graduates from hospital diploma schools. Today this figure is less than 75%. It is my impression that the A.N.A. dictum of 1964 advocates that bedside nursing will be relegated to technicians and aides.

The decision of the A.N.A. is neither without merit nor is it unique. It is in part a way of life and a product of our times. The desire and the goal of both our youth and parents today is the pursuit of a college education. The A.N.A. has felt, therefore, in order to raise the status of the nursing profession, it must establish schools within the "ivory towers" of a university so that a degree may be procured. This is all to the good, but hospital administrators and the medical profession wonder whether a college degree will fundamentally offer the ailing patient better nursing care at the bedside, which is the ultimate concern and mission of the Florence Nightingales and the Clara Bartons.

According to Dr. Thomas Hale, Executive Vice President of the Albany Medical Center Hospital, a survey of competency of graduates of a two-year associate degree program in New York State, made by the State Hospital Association in 1965 and 1966 showed that these graduates were "incompetent in giving safe bedside care, giving of treatments or taking charge of floors." He further added "that graduates of most four-year baccalaureate programs are little better qualified if any." Moreover, there is a feeling among some that a collegiate program may actually deter RN's away from hospital nursing. A recent report on a study of graduate collegiate nurses revealed 45% of the graduates preferred work in the field of public health, and 40% of the graduates placed psychiatric nursing high on the

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list. Who then is going to attend the sick in the hospitals of our country?

It is the intent of the A.N.A. to abolish the hospital diploma schools of nursing and the one-year practical nursing schools. Its goal is to leave only the two year associate degree programs in a junior college and the four-year baccalaureate program. The two-year program will eventually absorb the older hospital schools. Its graduates will be called nurse technicians and will be placed under the direction of the professional nurse — the degree holder. The care of the patient will be in the hands of the technician.

There appears to be a dichotomy of philosophy. If we are to obtain more nurses to meet the ever increasing need of our hospitals for the ever increasing patient load, where are we then to obtain them if the majority of collegiate nurses do not seek staff positions in hospitals? What will be the benefit of the degree and higher education if bedside nursing, the ultimate mission of the profession, is to be relegated to nurse technicians and aides?

It is true that the diploma program has lost some of its glamor and dedication and the trend to obtain a degree is mounting. The financial cost and burden of educating nurses in an entirely hospital setting cannot continue to be added to the hospital bill of the patient. What then are the solutions?

1. It is time for the American Medical Association to appoint a nursing committee to sit in conference with its sister professionals, the A.N.A. and the National League for Nursing, and freely discuss and exchange views which may be dividing them.

2. These two professions should invite the educational group of the American Hospital Association to take part in solving their differences and uniting their aims in a realistic program that will best benefit the sick in our hospitals.

3. Colleges and junior colleges alike should establish nursing education programs in settings where the availability of clinical material is plentiful.

4. State licensing boards should consider establishing a requirement of a twelve month internship for the graduate of a two-year or four-year collegiate program before granting a license for the practice of nursing.

5. State and Federal governmental agencies should financially support, in part at least, the cost of educating nurse applicants. The government today will give financial support for building of hospitals, and yet it has woefully neglected the most vital link — the nurses who will staff these institutions and care for the sick.

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Adverse Reactions: With higher than indicated doses manifestations of central nervous system effects such as nervousness, insomnia, dizziness, lightheadedness, drunken feeling, slurred speech, ataxia, inability to concentrate and some psychic reactions including depression and feelings of detachment were seen. Occasional blurred vision was reported at higher doses. Some of the milder and less pronounced symptoms above have been reported in a small number of patients taking the recommended dosage of 200 mg per day. Those were mostly transient and disappeared with continued administration of the drug. Some geriatric patients developed paranoid or hallucinatory behavior and became unmanageable while taking 200 mg daily. Medically unselected seriously deteriorated geriatric patients showed poor clinical tolerance after several weeks of daily dosing with 200 mg per day. One elderly patient with a history of prior cerebrovascular accident developed visual hallucinations and grand-mal convulsions while on drug at 800 mg per day. Some cases of dry mouth, gastrointestinal upset and skin rash and rarely, tremors, anorexia, pollakiuria, and nocturia have been also reported.

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MENTAL HEALTH MANPOWER

Manpower shortage in the field of mental health constitutes one of the most acute problems confronting us in the development of the community mental health programs, not only here in Springfield but across the country. Many and varied recommendations have been formulated in an attempt to solve it — some practical, others unrealistic and impossible of attainment. Among the recommendations made have been the following:

1. Enlarging and expanding training institutions,
2. Adjusting the patterns of training to meet the new demands of community mental health,
3. Continuing education for existing personnel,
4. Job reclassification and upgrading skills of available personnel,
5. Development of new mental health roles,
6. Redesigning the total structure of medical education in the United States, and
7. Reconceptualization of mental disease.

Dr. Harold Lief of Tulane Univsity in a recent article points with alarm to the current acute shortage of manpower in the mental health field and predicts that it will get worse. Even if there were to be an increase in the number of psychiatrists, psychologists, psychiatric social workers, and psychiatric nurses; there would still be insufficient personnel for the hundreds of mental health centers projected throughout the country. He contends that additional personnel trained in new ways for specific tasks and more participating community services will be required.

Changing Patterns

Dr. Lief also points to the already changing patterns in medical care, structured in an attempt to meet the overwhelming population growth, and predicts that the main centers for psychiatric care will be the general hospital and the community mental health center. He supports this with thought-provoking statistics that, in his opinion, indicate a greater trend toward institutionalization. For example, in ten years emeregency visits by patients to hospitals doubled from 16 million in 1954 to nearly 33 million in 1963. The percentage of physicians in private practice declined from 86% in 1931 to 63 % in 1964. These changes have been paralled by a marked increase in group practice and the establishment of clinics. Patients anticipate that they can get the best medical care in an institution rather than in a private office.

The Coggeshall Report states: "The trend toward institutionalization is well advanced. There is no reason to believe that it will be reversed or that its pace will slacken." The inference is that, with the advent of the community mental health centers, the trend toward institutionalization will accelerate and will have an important bearing on the type of psychiatric care.

One sees in all of this an emerging team approach which, incidentally, is not new in psychiatry. Child guidance clinics have always utilized the team approach, in which the psychiatrist, psychologist, and psychiatric so-

(More on Page 12)

cial worker collaborated in the total treatment program for the patient. With the increased need for the team approach, there will be a shifting of the primary site of medical care from the office to the clinic. This inevitable will give rise to increasing the number of nonmedical therapists working under the guidance of psychiatrists.

One Approach

Sub-professional training has been suggested as an alternative solution to the manpower shortage in Mental Health Centers. The Coggeshall Report frankly states: "In areas of critical shortage in mental health, for example, greater progress would be possible if more physician enthusiasm and aggressive interest in developing lay helpers were to be found," particularly since a new group of people specifically trained to work as members of a psychiatrist-led team in clinics and hospitals is needed.

Dr. Lief's conviction that one would not question, is that the medical profession cannot mobilize sufficient manpower by itself to even come close to getting the job in mental health done. This being the case, it is necessary that psychiatrists take the lead in planing for a new type of mental health therapist — a lay person who will be trained to be an assistant to the psychiatrist and other members of the mental health team.

Again quoting from the Coggeshall Report: "The future will see more health care demanded and provided than ever before. More physicians must be trained as quickly as possible. Since it is not likely that America will ever be able to produce enough physicians to satisfy growing national needs, it is essential that physician productivity be increased through delegation of specific tasks to others."

A similar idea was expressed in "Action for Mental Health," in which it proposed creating a new person carefully trained in psychotherapy without the lengthy basic medical and clinical training requiring 13 or 14 years beyond high school. Presumably such a person would work under the supervision of a psychiatrist.

The increasing demands for service in the mental health field and the paralleling pressures dictate that some utilization of a sub-professional group of mental health "associate therapists" be seriously considered.

Dr. Lief very realistically says: "Something has to be done or else we will have fine new buildings, lots of patients, and completely inadequate staffs. This is a time when we have to take a leap forward in our thinking if we are to solve the manpower shortage."

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THE COMPLEAT L. M. D.

It is very difficult, nay, even painful, to write of the demise of a colleague who gave so generously of himself to his patients, the public, and his fellow physicians.

The only way to describe the late Dr. Ralph T. Miller of Ware, is that he was a man selflessly dedicated to the noblest qualities and traditions of our profession. In witness thereof we need but mention a few of the services he rendered to organized medicine. He was a past president of the HDMS and of The Springfield Academy of Medicine. He served on countless committees, and at the time of his death was chairman of the Scholarship Committee, a member of the By-laws Committee, the Mental Health Committee, the Advisory Committee on Utilization, the Diabetes Detection Committee and a Director of the Charitable and Educational fund of The MMS. He was also alternate to the Executive Councilor of our District Society. Who can possibly match this record?

Very few of us have attended as many meetings and post-graduate courses as Ralph did, and this notwithstanding the long distance he had to travel to Springfield or Boston.

The death of Dr. Miller will be especially felt by The "Hampden Hippocrat" on whose Board of Editors he served for many years. No assignment seemed too difficult for him. He took special pride in reporting the MMS Council meetings — a feature originated by him several years ago.

Those of us who were privileged to know him more intimately could not help admiring his kindness, his keen sense of humor, and his love of people. His hobbies were skiing, flower raising and listening to good music. During his long terminal illness he exhibited unusual fortitude, patience, and equanimity.

Although blessed with many top notch workers, our Society can ill afford to lose men of Dr. Miller's caliber. Physicians imbued with his kind of spirit and enthusiasm are not easily replaceable. His untimely death will be profoundly felt by every member of our Society.

" . . . any man's death dimishes me,
because I am involved in Mankind."
—John Donne, Devotions

Millman

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IN MEMORIAM

LOUIS E. HATHAWAY, JR., M. D.

Dr. Louis E. Hathaway, Jr., of Hall Hill Rd., Somers, Conn., died at The Springfield Hospital on January 8, 1967.

Born in Fall River, Mass., on April 23, 1901, Dr. Hathaway graduated from Brown University in 1924 and received his M.D. degree from Harvard Medical School in 1928. After serving his internship and residency in surgery at the Boston City Hospital, he came to Springfield in 1931 to enter private practice.

Dr. Hathaway served on the medical staff of The Springfield Hospital for many years being President thereof at one time. He also served on the staff of the Wesson Memorial Hospital. He was a member of the A.M.A., the American College of Surgeons, the Mass. Medical Society, and the Hampden District Medical Society. During World War II, he served with the U.S. Navy Medical Corps.

Deepest sympathy is hereby extended to his family and to his many friends and associates.

RALPH T. MILLER, M. D.

Dr. Ralph T. Miller of 63 Chestnut St., Ware, Mass., died at the Mary Lane Hospital, Ware, Mass., on January 11, 1967.

Born in Elmsdale, Nova Scotia, Canada, on March 12, 1902, Dr. Miller attended the University of Dalhousie, Halifax, Nova Scotia and received his M.D. therefrom in 1925. After interning and residency training at Long Island Hospital, New York, 1925-1926 and 1928-1930; the New Haven Hospital, New Haven, Conn., 1927-1928; and the Children's Hospital, Boston, Mass., 1926-1927; he came to Ware in 1931 to engage in the private practice of pediatrics, obstetrics, and general medicine.

Dr. Miller served on the medical staffs of the Mary Lane Hospital, Ware, Mass., and the Wing Memorial Hospital, Palmer, Mass., for many years. He was a member of the A.M.A.; the Mass. Medical Society; the Hampden District Medical Society, of which he was President in 1962-1963; the Springfield Academy of Medicine, of which he was President in 1955-1956; the New England Pediatric Society; and New England Obstetrical and Gynecological Society.

Deepest sympathy is hereby extended to his family and to his many friends and associates.

IN MEMORIAM

PHILIP H. CLARKE, M. D.

Dr. Philip H. Clarke of 25 Claren Dr., Holyoke, Mass. died at the Holyoke Hospital on January 12, 1967.

Born in Holyoke, Mass., on March 5, 1892, Dr. Clarke attended Hamilton College and Harvard University and received his M.D. degree from the College of Physicians and Surgeons at Columbia University, New York, in 1915. He then interned at the Kings County Hospital, Brooklyn, N.Y. from 1915 to 1917. After World War I, during which he served in the U.S. Army Medical Corps., Dr. Clarke returned to Holyoke to engage in the general practice of medicine.

Dr. Clarke served on the medical staff of the Holyoke Hospital for many years. He was a member of the A.M.A., the Mass. Medical Society, the Hampden District Medical Society, and the Springfield Academy of Medicine.

Deepest sympathy is hereby extended to his family and to his many friends and associates.

YOUR COMMITTEE OF CHOICE

In order to insure the widest possible participation in the H.D.M.S.'s affairs, I am hereby inviting and urging members who have a particular interest to name the committee on which they would like to serve. Needless to say, the effectiveness of a committee is in direct proportion to the interest and concern of its members.

In the forepart of the "Hippocrat" is a complete listing of the Society's committees. Simply by dropping a note or calling the H.D.M.S. office at 1414 State St., Springfield, Mass. - 01109, your interest and prefernce will be given most serious consideration for appointment. Moreover, you will be rendering a distinct service to your profession, your community, and your Society.

Committee work is the heart of any organization. I urge you to let us know where you wish to apply your talents and energies.

Vice President and President-Elect
Joseph M. Baker, M. D.

EXECUTIVE COMMITTEE MEETING
(Highlights)

The Executive Committee met on January 17, 1967, in the Society's conference room. Present were Drs. Hayes, Griffin, Burkhardt, Nero, Baker, Beauchamp, Jr., Moore, Wiedman, Bloom, Stoler and Mrs. Purdy.

The meeting was called to order at 8:10 P.M.

The minutes of the December meeting were read by Dr. Griffin and approved as read.

Three letters were read as informational.

Committee Reports

Dr. Hayes read "Health Service Guidelines" set up by the Public Health Committee for implementation of the Elementary and Secondary School Act of 1965.

Health Service Guidelines

The following is a suggested guideline for use by personnel involved in evaluation of the problem child. These have been formulated by the Public Health Committee of the Hampden District Medical Society as a basis for discussion and implementation to make these services effective. Mutual understanding and cooperation between educational and medical persons are paramount for a successful program.

1. Referrals to the Special Psychological Services will include the physically or emotionally handicapped child.
   - A. The referrals to the program should be made through the office of the Social and Psychological Services by principals, teachers or family physicians who feel that in their opinion, the pupil may have a problem that is interferring with his school work.
   - B. A social worker should work with continuity with each pupil (and family) to provide responsible liaison for necessary health care and other supervision required to achieve our goals.
   - C. All pupils should be screened by audiometric and visual methods to rule out gross hearing and visual defects.
11. **Physical Examination**
   - A. The pupils referred are to be examined by physicians trained and interested in the care of children. This examination is to consist of a history, review of symptoms and a physical examination to include a neuro-muscular evaluation. The laboratory workup is to include hemoglobin, urinalysis including microscopic examination. Further laboratory diagnostic studies should be carried out as appropriate. Current immunization status should be determined and parents advised as to future need. Treatment should be carried out (within the concepts of this program) by physicians interested and competent in the care of children (including his family physician) and other medical specialists as needed. A free choice of a needed specialist should be made by the parents with guidance of the physician if requested. Appropriate special services, such as speech evaluation should be instituted

where necessary. A written report of the initial and other examinations shall be submitted to the Medical Advisory Committee through the office of Social and Psychological Services.

B. The evaluations are to be made by appointment in the physician's office. If the patient lacks transportation, arrangements should be made by social services. It is necessary that a parent or other responsible party accompany the pupil to the physician's office.

III. **Follow-Up Services**

A. Follow-up services should be carried through. These should include diagnostic, curative, and rehabilatative services as inpatient or out patient, as necessary within the scope of this program.

B. For those who are found to have hearing or visual problems, appropriate measures should be taken.

C. Comprehensive dental care should be provided if necessary.

D. If, at the discretion of the director, further evaluation is desired, the case should be reviewed with the Medical Advisory Committee for guidance.

IV. **Role of the Nurse**

A. The Public Health Nurse can assist in the liaison between parents, doctors, and medical agencies

B. The nurse can also take the lead in teaching proper health habits and rudiments of general standards of sanitation to both parents and children.

C. She will help interpret physicians findings to school personnel and parents.

These were approved by the Committee; copies with an appropriate covering letter will be sent to the Psychological Services of the Springfield schools. A sub-committee to act on a medical advisory basis has been appointed. Dr. Twible will serve as Chairman with Drs. Newmark, Devlin, and Zadworny assisting.

Dr. Boss, Jr., Chairman of the Mental Health Committee sent an informational report to the Committee.

Mrs. Purdy gave a report of activities of the office of HDMS.

The meeting was adjourned at 9:10 P.M.

The Committee met as the Grievance Committee and heard two cases.

The committee adjourned at 10 P.M.

#

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THE HOLYOKE HOSPITAL EXPANDS

On January 15, 1967, the Holyoke Hospital held an "open house" for public viewing of its new addition. The new two-story wing, intended for opening on or about the first of February, will provide 106 medical and surgical beds with a 13 bed intensive care unit, a 23 bed pediatric dept., a 13 bed recovery room, a new physical therapy dept., and expanded and modernized laboratory and radiology facilities.

The construction program also included remodeling of the first and second floors of the existing building for the purpose of centralizing the dietary dept., remodeling the cafeteria, renovating the surgical suite, and expanding the business and administrative offices. Parking facilities for employees and the public have been increased from 155 spaces to more than 300; moreover, the front driveway has been redesigned to expedite all traffic. The original aim of the project was to eliminate the use of the old wing of the Hospital; however, this phase out will have to be gradual due to the increased patient load, long waiting lists, and the increased demand for in-patient care brought on by Medicare.

The total cost, including furnishings and architectural fees is in excess of 3 million dollars for this phase of the Hospital's long range development program. Pledges during the fund raising campaign begun in 1964 have amounted to $1,091,733; local banks have also joined to share a mortgage of $1,250,000; and support has also come from a federal grant under the Hill-Burton program for the present development phase.

The second phase of the program, already under way and on the drawing boards, will include completion of modern service facilities in the basement of the new wing and the eventual construction of the third, fourth, and fifth floors thereon.

The Holyoke Hospital observed its diamond jubilee during 1966, and the current year bodes to be a significant beginning for the progress in service to the Holyoke community.

Maher

MERCY HOSPITAL TO BUILD

Bishop Weldon announced recently the selection of an architect for the new Mercy Hospital.

(1) The new Mercy Hospital, he announced, will not be built at the present location. The site for the new hospital has not been selected as yet.

(2) The new hospital will have a minimum of 400 beds and will be constructed so that it may be enlarged if necessary.

(3) The present hospital will not be discarded. Present plans call for it to be used for some other purpose, which has not yet been determined.

#

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VITALLY SPEAKING

An unofficial analysis of death certificates of Springfield residents for 1966 revealed that a total of 1711 persons died during the year. This figure does not include those Springfield resident deaths occurring outside of the City.

The ten leading causes of death were:

1.	Diseases of the heart	682
2.	Neoplasms	255
3.	Cerebrovascular Lesions	224
4.	Pneumonia (all types)	125
5.	Accidents	86
6.	Diseases of Circulatory System	50
7.	Cirrhosis of Liver	49
8.	Bronchitis	41
9.	Diseases of Early Infancy (Under 4 weeks of life)	38
10.	Diseases of Skin & Cellular Tissue (Skin and Locomotor system)	20
	Total	1,570

Deaths from heart disease lead the list with 40%; next, cancer with 14%; third, cerebrovascular diseases with 13%; fourth, pneumonia with 7%; fifth, accidents with 5%. There were *no maternal deaths nor tuberculosis deaths.* Approximately 77% of the deaths were amongst those sixty years and above. Males predominated over females in the ratio of 1.08 to 1. As in the recent past, these mortality statistics point up the fact that chronic diseases, particularly those of the cardiovascular system are the major health problems of Springfield.

Deaths from infectious diseases during 1966 were due to:

Pneumonia	125
Bronchitis	41
Meningoccal Infection	1
Meningitis	4
Tetanus	1

Only 6 deaths were due to diseases considered to be officially dangerous to the public health. Most of the pneumonia and bronchitis deaths were undoubtedly a terminal insult superimposed upon some other prolonged, strength sapping disease process.

The reported cases infectious diseases were:

Reported Communicable Diseases in Springfield - 1966

Chickenpox	113
Dysentery	6
Encephalitis	4
German Measles	7
Hepatitis	34
Measles	13
Meningitis	18
Mumps	280
Polio	0
Salmonella	28
Scarlet Fever	98
Strep. Throat	437
Tetanus	1
Tuberculosis	17
Whooping Cough	3

Although there is obviously an underreporting of the common communicable diseases of childhood, it is quite gratifying to see the low incidence of infectious diseases for which there are effective immunizing agents. The persistent prevalence of infectious hepatitis is most disturbing.

Analyzing the 86 deaths occurring in 1966 due to accidents, some interesting facts come to the fore. First of all, 39 occurred in the home, were due to

(More on Page 22)

falls, and involved 14 men and 25 women with all deaths but one occurring in the 50 and above group. Secondly, 27 persons were killed in traffic accidents with 17 in automobiles - 9 drivers and 8 passengers - and all between the ages of 10 to 50 years of age. Seven pedestrians were killed as well as two motorcylists and one child bicyclist. Nine persons died in fires or from burns and four drowned. Other deaths were due to aspiration of food - one infant, carbon monoxide poisoning - two, impaction of paper in larynx - one infant, hunting rifle shot - one middleaged male, and sodium pentothal poisoning - one elderly male.

Looking at mental health connotations, it might be noted that there were 17 suicides (9 males and 8 females) with deaths beginning in the 10-19 year age group and occurring in each ten year grouping reaching a maximum of 5 in 40-49 year old grouping and continuing to 80 years of age.

Secondly, there were 8 homicidal deaths - 5 male and 3 females.

Although there were no maternal deaths, there were 25 stillbirths reported. There were also 64 infant deaths (under 1 year of age) with 38 being due to certain diseases of early infancy, 7 due to pneumonia; 5 due to congenital malformations; 3 due to accidents; 3 due to diseases of skin and cellular tissue; 2 each respectively due to cerebro-vascular lesions, bronchitis, and ill-defined causes; 1 each respectively due to diabetes mellitus, and meningitis.

Ayres

ATTENTION COMMITTEE CHAIRMEN!

Committee reports that are purely informational in character need not be presented at the Annual Meeting. Instead, they will be published in the April issue of the *Hippocrat.*

The only requirements are: (1) that the report not exceed 300 words; (2) that the original report reach Society headquarters not later than March 15; and (3) that a copy of the report reach the desk of the Editor-in-Chief not later than March 15.

Reports containing "recommendations" will have to be presented at the Annual Meeting.

Chairmen of sub-committees will not present reports at the Annual Meeting. They will instead report to their respective parent committees.

Your cooperation is urgently requested.

John F. Griffin, M. D., Secretary

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HAMPDEN CAPSULES

Dr. Ahmed I. Mouchantant was recently certified by the American Board of Surgery.

— —

Dr. Jack H. Pincus was recently certified by the American Board of Ophthalmology.

— —

Dr. John M. Maloney has been named a consulting editor of a new Miller & Fink publication called "Patient Care."

— —

Dr. John M. Maloney and Dr. Walton E. Stevens both delivered papers at a recent meeting of the New England Chapter of Nuclear Medicine in Boston.

— —

Dr. Leon M. Kruger recently presented a paper on a surgical technique for correcting a chronically bent knee at the annual meeting of the Academy of Orthopedic Surgeons in San Francisco.

— —

Speaking

Dr. Helen Harmand against smoking at the West Springfield High School.

Dr. Howard Turner against smoking at the Sumner Ave. School, Springfield.

Dr. Zadworny with film "Human Growth" at the Tapley School, Springfield.

Dr. Galuszka with film "Human Growth" at the Szetela School, Chicopee.

Transfers

Dr. William Kaufman to non-resident member of M.M.S.

Survey

Questionnaires recently mailed to members relative to family statistics yielded the following:

Number sent out	514
Number returned	209
Number of boys	330
Number of girls	335
Ages to 10 years	235
Ages to 18 years	233
Ages over 18 years	185
Families with 10 children	2
Families with 8 children	4
Families with 7 children	7
Families with 6 children	7
Families with 5 children	22
Families with 4 children	24
Families with 3 children	59
Families with 2 children	60
Families with 1 child	20
Families with no children	5

— —

Family Style

Congratulations to:

Mrs. Elmer Franseen and Mrs. Stanley Dixon for "Orchids to You" from the Springfield Daily News. This makes four physicians' wives so honored.

Mrs. James Hartshorn for her article in the "Bay Stater", December issue entitled "Pollution - An Old Problem Grows Worse!" #

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ACADEMY

The next meeting of the
SPRINGFIELD ACADEMY OF MEDICINE
will be held on
TUESDAY, MARCH 14, 8:30 P.M.

SPEAKER:	JOSEPH M. FOLEY, M.D. Department of Medicine Lakeside Hospital Cleveland, Ohio
TOPIC:	"THE MENTAL CHANGES of OLD AGE"
PLACE:	Auditorium, Municipal Hospital Springfield
HOSPITAL CLINIC:	Providence Hospital, Holyoke, 5:00 P.M.

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THE SPRINGFIELD HOSPITAL EDUCATIONAL PROGRAM

Victor C. Vaughn, III, M.D., Medical Director, St. Christopher's Hospital for Children and Professor and Chairman, Dept. of Pediatrics, Temple University, Phildelphia, Pa., will be the pediatric guest speaker on Thursday, March 2, 1967. His topic will be "New Insights in Social Behavior." A clinical session will be held at 5:00 P.M.; pediatric rounds at 6:00 P.M.; and the formal presentation, at 8:00 P.M.

Leroy D. Vandam, M.D., Professor and Chairman, Dept. of Anesthesiology, Peter Bent Brigham Hospital, Boston, will present a lecture entitled "Anesthetic Management of the Patient with Coronary Arterial Disease" on Friday, March 17, 1967 at 7:30 P.M. in the Hospital's Auditorium.

All physicians, residents, interns, nurses, and military personnel are cordially invited to attend.

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COMING EVENTS

JOINT HAMPDEN BAR ASSOCIATION AND H.D.M.S. MEETING, MARCH 7 **(See Page 9)**

HAMPDEN DISTRICT ANNUAL MEETING, APRIL 24

H.D.M.S. EXECUTIVE COMMITTEE MEETINGS, MARCH 21 AND APRIL 17

ACADEMY OF MEDICINE, MARCH 14 AND APRIL 11 (See Page 25)

AMA - ABA NATIONAL MEDICOLEGAL SYMPOSIUM, MIAMI BEACH, FLA., MARCH 9 - 11

MMS COUNCIL MEETING, MAY 15

MMS ANNUAL MEETING, BOSTON, MAY 16, 17, AND 18

AMA ANNUAL MEETING, ATLANTIC CITY, N.J., JUNE 18 - 22

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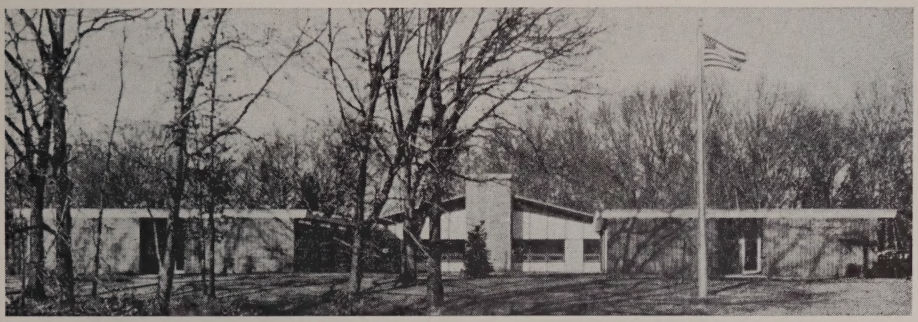

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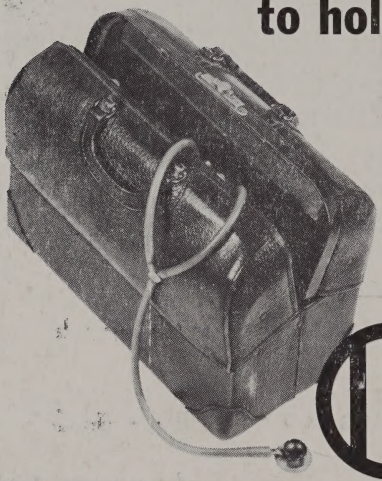

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